# CHAPTER V

# BILLING INSTRUCTIONS

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# CHAPTER V
# BILLING INSTRUCTIONS

## INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

## ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741
Fax number: (804)-273-6797
First Health's. website: http://virginia.fhsc.com, or by mail

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

## GENERAL INFORMATION

Timely Filing

DMAS regulations require the prompt submission of all claims. Federal regulations require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late

claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a dated letter from the local department of social services (DSS) which specifies: that the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of delayed eligibility. A copy of the dated letter from the local DSS indicating the delayed claim information must be attached to the claim; to request individual consideration, enter an explanation in the "Remarks" section of the invoice.

  For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

- **Denied Claims** - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the invoice as usual, explaining the reason for the late submission in the "Remarks" section of the invoice.

  - **Attach** written documentation to verify the explanation. The attached documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the 12-month period. (The DMAS-3 form is to be used by electronic billers for attachments).

  - Request individual consideration for the invoice by entering an explanation in the "Remarks" section of the invoice.

  - Submit the claim in the usual manner by mailing the claim to:

Department of Medical Assistance Services
P. O. Box 27443
Richmond, Virginia 23261-7443

- Submit an original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid, as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services must be billed to Medicaid within 12 months from the date of the service. If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

## REPLENISHMENT OF BILLING MATERIALS

The hospice provider must purchase the UB-92 form. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS web site (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call: 1-(804)-780-0076.

## REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

## ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800)-924-6741.

## CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers

| | |
|---|---|
| 1-804-786-6273 | Richmond Area and out-of-state long distance |
| 1-800-552-8627 | In-state long distance (toll-free) |

Enrollee verification and claim status may be obtained by telephoning:

| | |
|---|---|
| 1-800-772-9996 | Toll-free throughout the United States |
| 1-800-884-9730 | Toll-free throughout the United States |
| (804) 965-9732 | Richmond and Surrounding Counties |
| (804) 965-9733 | Richmond and Surrounding Counties |

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

## PAYMENT METHODOLOGY

The Provider Reimbursement Division determines rates for hospice providers. If you have any questions regarding the rates, please contact the Provider Reimbursement Division at (804) 786-7931. Please see the rate schedule in the "Exhibits" section at the end of this chapter.

## HOSPICE PAYMENT PROCESS

Send all invoices for hospice services directly to the fiscal intermediary for processing. The address for sending hospice invoices is:

DMAS
P.O. Box 27443
Richmond, Virginia 23261-7443

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures
- Sharing clarification on a concern expressed by a provider

Electronic Filing Requirements

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions after December 31, 2003 are no longer accepted, and all local service codes are no longer accepted for claims with dates of service

after December 31, 2003. All claims submitted with dates of service after December 31, 2003 will be denied if local codes are used.

On June 20, 2003, DMAS began accepting EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated). Beginning with electronic claims submitted on or after January 1, 2004, DMAS accepts only HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes are accepted for claims with dates of service on or after June 20, 2003. National Codes became mandatory for claims with dates of service on or after January 1, 2004.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

## CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

## UB-92 (CMS-1450) BILLING INSTRUCTIONS

Instructions for Completing the UB-92 (CMS-1450) Universal Claim Form

The UB-92 (CMS-1450) is a universally accepted claim form that is required when billing DMAS for covered services. This form is readily available from printers. The UB-92 (CMS-1450) **will not** be provided by DMAS. (See "Exhibits" at the end of this chapter for a sample of this form).

### General Information:

The following information is applicable to Medicaid claims submitted by the provider on the UB-92 (CMS-1450):

- All dates used on the UB-92 (CMS-1450) must be two digits each for the day, the month, and the year (e.g., 010403) with the exception of Locator 14, Patient Birthdate, which requires four digits for year.

  **NOTE: NO SLASHES, DASHES OR SPACES ARE ALLOWED.**

- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

- Do not record cost reduction copayments on this form.

- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

- To adjust a previously paid claim, complete the UB-92 (CMS-1450) to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 817 for Hospice or 827 for Inpatient Hospice and, in locator 37, enter the nine to sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher. Enter the reason code and an explanation for the adjustment in Remarks, Locator 84.

- To void a previously paid claim, complete the following data elements on the UB-92 (CMS-1450):

  - Bill Type 818 for: Routine Home Care, Continuous Home Care, Inpatient Respite Care (if not provided in hospital setting), General Inpatient Care (if not provided in hospital setting), and Nursing Facility Resident

  - Bill Type 828 for: Inpatient Respite Care (in a hospital setting), and General Inpatient Care (in a hospital setting)

  - ICN/DCN (Locator 37) - Enter the nine to sixteen digit claim reference

number of the paid claim to be voided. Enter the reason code and an explanation in Remarks, Locator 84.

- Payer Indicator (Locator 50) - Enter "Medicaid" here.
- Medicaid Provider Number (Locator 51) - Enter the Medicaid provider number.
- Recipient ID Number (Locator 60) - Enter the enrollee's Virginia Medicaid number.

## UB-92 (CMS-1450) INVOICE INSTRUCTIONS

The following description outlines the process for completing the UB-92 CMS-1450. It includes Medicaid specific information and should be used to supplement the material included in the *State UB-92 Manual*.

| Form Locator (FL) | | Instructions |
|---|---|---|
| **1** | **Required** | Enter the provider's name, address, and telephone number. |
| 2 | Unlabeled Field | |
| **3** | **Required (if applicable)** | **PATIENT CONTROL NO. -** Enter the patient account number. These account numbers may be all numeric digits or a combination of alpha and numeric, but cannot exceed 17 alphanumeric characters. |
| **4** | **Required** | **Type of Bill** – Enter the code as appropriate. For billing on the UB-92, the only valid codes for Virginia Medicaid are:<br><br>811 Original Nursing Facility Hospice Invoice<br>817 Original Nursing Facility Hospice Invoice - Adjustment<br>818 Original Nursing Facility Hospice Invoice - Void<br><br>**NOTE:** For the above bill types, the revenue code that is billed for Nursing Facility services which are provide by Hospice is 0658 – Nursing Facility Resident.<br><br>821 Original Inpatient Hospital Hospice Invoice<br>827 Original Inpatient Hospital Hospice Invoice - Adjustment<br>828 Original Inpatient Hospital Hospice Invoice – Void<br><br>**NOTE:** For the above bill types, the revenue code that is billed for Inpatient Hospital Services which are provided by Hospice are 0653 – General Inpatient Care **OR** 0655 – Inpatient Respite Care.<br><br>831 Original Outpatient Hospice Services Invoice<br>837 Original Outpatient Hospice Services Invoice – Adjustment<br>838 Original Outpatient Hospice Services Invoice – Void |

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | **NOTE:** For the above bill types, the revenue code that is billed for Outpatient Services which are provided by Hospice are 0651 – Routine Home Care **OR** 0652 – Continuous Home Care.<br><br><u>For Medicare Crossover Claims:</u><br><br>These are claims where Medicare is the primary payer and the Department of Medical Assistance Services (DMAS) is secondary. Medicare claims will automatically crossover to Medicaid for payment of co-insurance and deductible balances. DMAS will then adjudicate the claim and pay any remaining balance up to our allowable amount.<br><br>For providers that have remaining nursing facility charges, that are not covered by Medicare, these charges would be billed with bill type 811 and revenue code 0658 (include your usual and customary charges). In locator 39, providers will indicate the appropriate Coordination of Benefits (COB) code (see locator 39). The payment from Medicare plus the payment by Medicaid for the co-insurance and deductible balances would be shown with COB code = 83. DMAS will calculate our standard reimbursement minus the total payment amount, indicated in locator 39. |
| 5 | Not required | FED. TAX NO. |
| **6** | **Required** | **STATEMENT COVERS PERIOD** - Enter the inclusive days being reported on the invoice. The "through" entry must be the last day billed. The date of death or discharge, if applicable, must be indicated.<br><br>The "Statement Covers Period" on the invoice must fall within one calendar month. When there is a claim for which the billing period overlaps calendar months, a separate invoice must be submitted for each calendar month. For example, an enrollee admitted to a nursing home on March 15 and discharged April 30. One invoice would be submitted for the period of March 15 through March 31, and one invoice would be submitted for the period of service in April. |
| **7** | **Required** | **COV D. (Covered Days)** - Enter the total number of Medicaid |

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | covered days as applicable. This must be the total number of covered accommodation revenue code units reported in Locator 46. |
| **8** | **Required (if applicable)** | **N-CD. (Non-Covered Days)** - Enter the days of care not covered. Non-covered days are not included in covered days and not claimable as Medicaid patient days on the cost report. |
| 9 | Not required | C-ID. (Coinsurance Days) |
| 10 | Not required | L-RD. (Lifetime Reserve Days) |
| 11 | Unlabeled Field | |
| **12** | **Required** | **PATIENT NAME** - Enter the patient's name - last, first, middle initial. |
| 13 | Not required | Patient Address - Enter the patient's address. |
| **14** | **Required** | **Birthdate -** Enter the month, date, and full year (MMDDYYYY). |
| **15** | **Required** | **Sex** - Enter the sex of the patient as recorded at the date of admission, outpatient service, or start of care. |
| **16** | **Optional** | **MS (Patient's Marital Status)** - Enter the marital status of the patient at the date of admission or the start of care. The codes are:<br>S = Single<br>M = Married<br>X = Legally Separated<br>D = Divorced<br>W = Widowed<br>U = Unknown |
| **17** | **Required** | **ADMISSION** - Enter the date of admission to the Nursing Facility for bill type 811 series and revenue code 0658. For all other bill types (821 series with revenue codes 0653 or 0655; OR 831 series with revenue codes 0651 or 0652) enter the start of care date for Hospice services. |
| 18 | Not required | HR (Admission Hour) |
| **19** | **Required (if applicable)** | **Type** (Type of Admission) – Enter the type of admission for any Inpatient Hospice Service for type 811 series and revenue code |

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | 0658; OR for bill type 821 series with revenue codes 0653 or 0655; enter the type of admission as Hospice services. |
| **20** | **Required** | **SRC (Source of Admission)** - Enter the proper code as follows:<br>1 Physician Referral (used for both Inpatient and Outpatient referrals)<br>2 Clinic referral (used for both Inpatient and Outpatient referrals)<br>3 MCO referral (used for both Inpatient and Outpatient Referrals)<br>4 Transfer from a hospital<br>5 Transfer from a skilled nursing home<br>6 Transfer from another health care facility<br>7 Emergency room<br>8 Court/law enforcement<br>9 Information not available<br>A Transfer from a critical access hospital |
| 21 | Not required | D HR (Discharge Hour) |
| **22** | **Required** | **STAT (Patient Status)** - Enter the status code as of the through date in Statement Covers Period (Locator 6). (If the patient was a one-day stay, enter code "30.")<br><br>DMAS does not pay for a nursing home bed to be held while a patient is hospitalized.<br><br>For a patient in the nursing home a whole month, the "from" date will be the first day of the month. The "through" date is the last day of the month (*e.g.,* from 03/01/03 through 03/31/03). The patient status code will be 30 (still a patient) which ensures payment for the last day.<br><br>When a patient is admitted to a hospital or discharged (*e.g.,* on 04/14/03), bill for 04/01/03 to 04/14/03, using the appropriate codes 1-8 (discharge codes). The day of death or discharge is not a covered day, so the accommodation days will be 13. Locators 6 |

**Form Locator (FL) Instructions**

and 46 must be coordinated and in agreement.

When status codes 1-8 are used in Locator 22, the "through" date is not a paid accommodation day.
If the patient returns to the nursing home, a second bill will begin the date of the return to the home. If the patient returns on 04/25/03, the second bill for April will have "from" date of 04/25/03 "through" date of 04/30/03, patient status of 30.

DMAS does not pay for a nursing home bed to be held while a patient is hospitalized.

**01 - Discharged to home or self care (routine discharge).**

**02 - Discharged/Transferred to another short term general hospital for inpatient care.** The date the patient was transferred is the "through" date in locator 6. This day cannot be included in the accommodation charges in locator 46.

**03 - Discharged/Transferred to skilled nursing facility (SNF).** The day the patient was transferred is the "through" date in locator 6. This day cannot be included in the accommodation charges in locator 46.

**05 – Discharged/Transferred to another type of institution for inpatient care or referred for outpatient services to another institution.** The date the patient was discharged must be reported in locator 6 as the "through" date. This day cannot be included in the accommodation charges in locator 46.

**06 - Discharged/Transferred to home under care of organized home health service organization.** The date the patient was discharged must be reported in locator 6 as the "through" date. This day cannot be included in the accommodation charges in locator 46.

**07 - Left against medical advice or discontinued care.** The date the patient left must be reported in locator 6 as the "through" date. This date cannot be included in the accommodation charges in locator 46.

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | **20 - Expired -** The date of death must be reported in locator 6 as the "through" date. This date cannot be included in the accommodation charges in locator 46. |
| **23** | **Optional** | **Medical Record No**. - Enter the number assigned to the patient's medical/health record by the provider for history audits.<br>**NOTE**: This number should not be substituted for the Patient Control Number (Loc. 3) which is assigned by the provider to facilitate retrieval of the individual financial record. |
| 24-30 | Not required | Condition Codes |
| 31 | Unlabeled Field | |
| **32-35** | **a-b Required (if applicable)** | **OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. |
| | | **01 - Auto Accident** - Code indicating the date of an auto accident |
| | | **02 - No Fault Insurance Involved-Including Auto Accident/Other -** Code indicating the date of an accident including auto or other where the state has applicable no fault liability laws (*i.e.,* legal basis for settlement without admission of proof of guilt) |
| | | **03 - Accident/Tort Liability -** Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability |
| | | **04 - Accident/Employment Related -** Code indicating the date of an accident allegedly relating to the patient's employment |
| | | **05 - Other Accident -** Code indicating the date of an accident not described by the above codes |
| | | **06 - Crime Victim -** Code indicating the date on which a medical condition resulted from alleged criminal action |

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | committed by one or more parties |
| 36 | Not required | Occurrence Span Codes and Dates |
| **37** | **a-c Required (if applicable)** | **INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine- to sixteen digit claim reference number of the paid claim to be **adjusted** or **voided**. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). See the instructions for adjustments and voids for the specific reasons.<br><br>**NOTE:** A = Primary Payer<br>B = Secondary Payer<br>C = Tertiary Payer<br><br>Cross Reference to Payer Identification in Locator 50 A, B, C (Payer Identification). |
| **38** | **Optional** | **Responsible Party Name and Address** |
| **39-41** | **Required** | **VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim.<br><br>The Medical Assistance Program is always the payer of last resort when other health insurance coverage is available. Thus, all other insurance companies must be billed and payment received before billing the Medical Assistance Program.<br><br>Other health insurance coverage will be provided at the time of verification of the enrollee's eligibility. This code consists of a three-digit numerical code denoting a possible carrier. Information for these carriers must be obtained by contacting the appropriate carrier.<br><br>**Each** claim submitted **must** include the appropriate code in locator 39 to indicate the primary carrier billing status.<br><br>One of the following codes **must** be used:<br><br>**82 - No Other Coverage -** If the enrollee has no insurance coverage other than Medicaid.<br><br>**83 - Billed and Paid -** The Medical Assistance Program must only be billed if the amount paid by the primary |

**Form Locator (FL) Instructions**

carrier is less than the charge for the covered services rendered. If the provider has received payment from the primary carrier(s) other than Medicare Part A, code 83 must be entered, all applicable charges must be entered, and the amount covered by the primary carrier entered under the amount section of the locator.

**85 - Billed and Not Paid -** It is possible that the health insurance coverage of the primary carriers may exclude a particular type of service that is covered under the Medical Assistance Program, or, after billing the primary carrier, it may be determined that the enrollee's other coverage for certain benefits may be exhausted. In either case, Code 85 must be entered. The use of Code 85 must be accompanied by an attachment that contains the following information: the name of the insurance, the date of denial, and the reason for denial or non-coverage. This denial must be part of the patient's record and available for audit.

**42 Required** **REV. CD. (Revenue Codes) -** Enter the appropriate revenue code(s) which identify a specific accommodation, ancillary service, or billing calculation.

Code = 4 digits, right justified, use leading zeros

0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day)

0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short–term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

0653 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day)

0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive

**Form Locator (FL) Instructions**

days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430)

0658 Nursing facility resident who has elected the hospice benefit (one unit = 1 day). Procedure code 0658 must be billed in conjunction with either procedure code 0651 (routine home care) or 0652 (continuous home care), which are billed as ouptatient services with bill type 831 (see below). Hospice will be reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.

For the bill type 811, 817, and 818 series, the revenue code that is billed for Nursing Facility services which are provide by Hospice is 0658 – Nursing Facility Resident.

For the bill type 821, 827, and 828 series, the revenue code that is billed for Inpatient Hospital Services which are provide by Hospice are 0653 – General Inpatient Care **OR** 0655 – Inpatient Respite Care.

For the bill type 831, 837, and 838 series, the revenue code that is billed for Outpatient Services which are provide by Hospice are 0651 – Routine Home Care **OR** 0652 – Continuous Home Care.

**43 Required** **DESCRIPTION - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the *State UB-92 Manual*).**

**44 Required** **CPCS/RATES -** Enter the accommodation rate.

45 Not required SERV. DATE - Enter the date the service was provided.

**46 Required** **SERV. UNITS -** Enter the total number of covered accommodation days or ancillary units of service where appropriate.

**47 Required** **TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period - total charges must include only covered charges.

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | **Instructions for "0001"**<br>Use revenue code "0001" for TOTAL. THIS REVENUE CODE MUST BE THE LAST CODE ENTERED IN LOCATOR #42. |
| **48** | **Required** | **NON-COVERED CHARGES** - Reflects non-covered charges for the primary payer pertaining to the related revenue code.<br><br>**Note**: Use revenue code "0001" for TOTAL Non-Covered Charges. (Enter the total for both total charges and non-covered charges on the same line of revenue code "0001.") |
| 49 | Unlabeled Field | |
| **50** | **A-C Required** | **PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill.<br><br>A = Enter the primary payer.<br>B = Enter the secondary payer if applicable.<br>C = Enter the tertiary payer if applicable.<br><br>When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. |
| **51** | **A-C Required** | **PROVIDER NO.** - Enter the Provider I.D. NUMBER on the appropriate line corresponding with the payer name in locator 50.<br><br>A = Primary<br>B = Secondary<br>C = Tertiary |
| 52 | A-C Not Required | REL INFO (Release Information) - Certification Indicator |
| 53 | A-C Not Required | ASG BEN (Assignment of Benefits) - Certification Indicator |
| **54** | **A, B, C, P Required (if applicable)** | **PRIOR PAYMENTS (Payers and Patients)**<br><br>**Note:** A = Primary<br>B = Secondary<br>C = Tertiary |

| Form Locator (FL) | | Instructions |
|---|---|---|
| | | P = Due from Patient<br>**Enter the patient pay amount on "P" line as shown on the DMAS-122 form furnished by the Local Department of Social Services. (See "Exhibits" at the end of this chapter for a sample of this form.)** |
| 55 | Not required<br>A, B, C, P | Est. Amount Due |
| 56 | Unlabeled<br>Field | |
| 57 | Unlabeled<br>Field | |
| **58** | **A-C Required** | **INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the name when eligibility is confirmed. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card.<br><br>Enter the insured's name used by the primary payer identified on Line A, Locator 50.<br><br>Enter the insured's name used by the secondary payer identified on Line B, Locator 50.<br><br>Enter the insured's name used by the tertiary payer identified on Line C, Locator 50. |
| **59** | **Required** | **(if P. REL applicable)** |
| **60** | **A-C Required** | **CERT.-SSN-HIC.-ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58.<br><br>**NOTE:** The Medicaid Enrollee ID# is 12 digits. |
| 61 | Not Required | Group Name |
| 62 | Not Required | Insurance Group No. |
| 63 | Not Required | Treatment Authorization Codes |

| Form Locator (FL) | | Instructions |
|---|---|---|
| 64 | Not required | ESC (Employment Status Code) |
| 65 | Not required | Employer Name |
| 66 | Not Required | Employer Location |
| **67** | **Required** | **PRIN. DIAG. CD.** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis.<br><br>**DO NOT USE DECIMALS.** |
| **68-75** | **Required (if applicable)** | **Other Diagnosis Code(s)** - Enter the codes for diagnoses other than principal if any.<br><br>**DO NOT USE DECIMALS.** |
| 76 | Not required | Adm. Diag. Cd. - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. |
| 77 | Not Required | E-Code (External Cause of Injury Code) |
| 78 | Unlabeled Field | |
| **79** | **Required** | **P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows:<br><br>5 - HCPCS<br>9 - ICD-9-CM<br><br>Refer to the *State UB-92 Manual* for other codes. |
| **80** | **Required (if applicable)** | **Principal Procedure Code and Date** - Enter the ICD-9-CM procedure code for the principal procedure performed during the billing period. |
| **81** | **Required (if applicable)** | **Other Procedure Codes & Dates** - Enter the code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal.<br><br>**DO NOT USE DECIMALS.** |

| Form Locator (FL) | | Instructions |
|---|---|---|
| **82** | **Required** | **ATTENDING PHYS. ID. NUMBER -** Enter the attending physician's seven to nine digit Medical Assistance Program identification number. If the physician does not participate in the Virginia Medical Assistance Program, use the following number 99-0002-1 (Practitioner, Non Participating). |
| **83** | **Required (if applicable)** | **OTHER PHYS. ID** - Instructions are the same as for the attending physician in locator 82 above. **If revenue code 0658 is billed, enter the nursing facility provider number in this block. The provider number is 9 digits.** |
| **84** | **Required (if applicable)** | **REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37). Also, if there is a delay in filing, indicate the reason for the delay here and include an attachment. Also, provide any other information necessary to adjudicate the claim. |
| **85** | **Required** | **PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. Required for paper claims only. |
| **86** | **Required** | **Date -** Enter the date on which the bill is submitted to Medicaid. Required for paper claims only. |

Adjustment Invoice Instructions

The UB-92 (CMS-1450) is used as an adjustment invoice to change information on a paid claim. Only one line may be billed on an adjustment invoice. Follow the previous instructions for completion of the UB-92 (CMS-1450) except for the locators indicated below:

| Form Locator (FL) | | Instructions |
|---|---|---|
| **4** | **Required** | **Type of Bill - Enter the type of bill:**<br><br>**817 Adjustment Nursing Facility Hospice**<br>**827 Adjustment for Inpatient Hospital**<br>**837 Adjustment for Outpatient Services** |
| **37** | **Required** | **Claim Reference Number** - Enter the nine to sixteen digit claim reference number of the paid claim. This number can be obtained from the remittance voucher and is required to identify the paid claim that is to be adjusted.<br><br>**Note**: Only a paid claim may be adjusted. The former reference number must be located on the same line that Medicaid is shown in locator 50. |
| **84** | **Required** | **Remarks -** Enter a brief explanation of the reason for the adjustment. |

Void UB-92 Invoice Instructions

The UB-92 (CMS-1450) is used as a void invoice when the full payment is to be returned to the Virginia Medical Assistance Program. Only one line may be billed on a void invoice. Follow the previous instructions for completion of the UB-92 (CMS-1450) except for the locators indicated below:

| Form Locator (FL) | | Instructions |
|---|---|---|
| **4** | **Required** | **Type of Bill - Enter the type of bill:**<br>**818 Adjustment Nursing Facility Hospice**<br>**828 Adjustment for Inpatient Hospital**<br>**838 Adjustment for Outpatient Services** |
| **37** | **Required** | **Claim Reference Number** - Enter the nine to sixteen digit claim reference number of the paid claim. This number can be obtained from the remittance voucher and is required to identify the paid claim that is to be adjusted.<br>**Note**: Only a paid claim may be adjusted. The former reference number must be located on the same line that Medicaid is shown in locator 50. |
| **84** | **Required** | **Remarks -** Enter a brief explanation of the reason for the void. |

## EDI BILLING (ELECTRONIC CLAIMS)

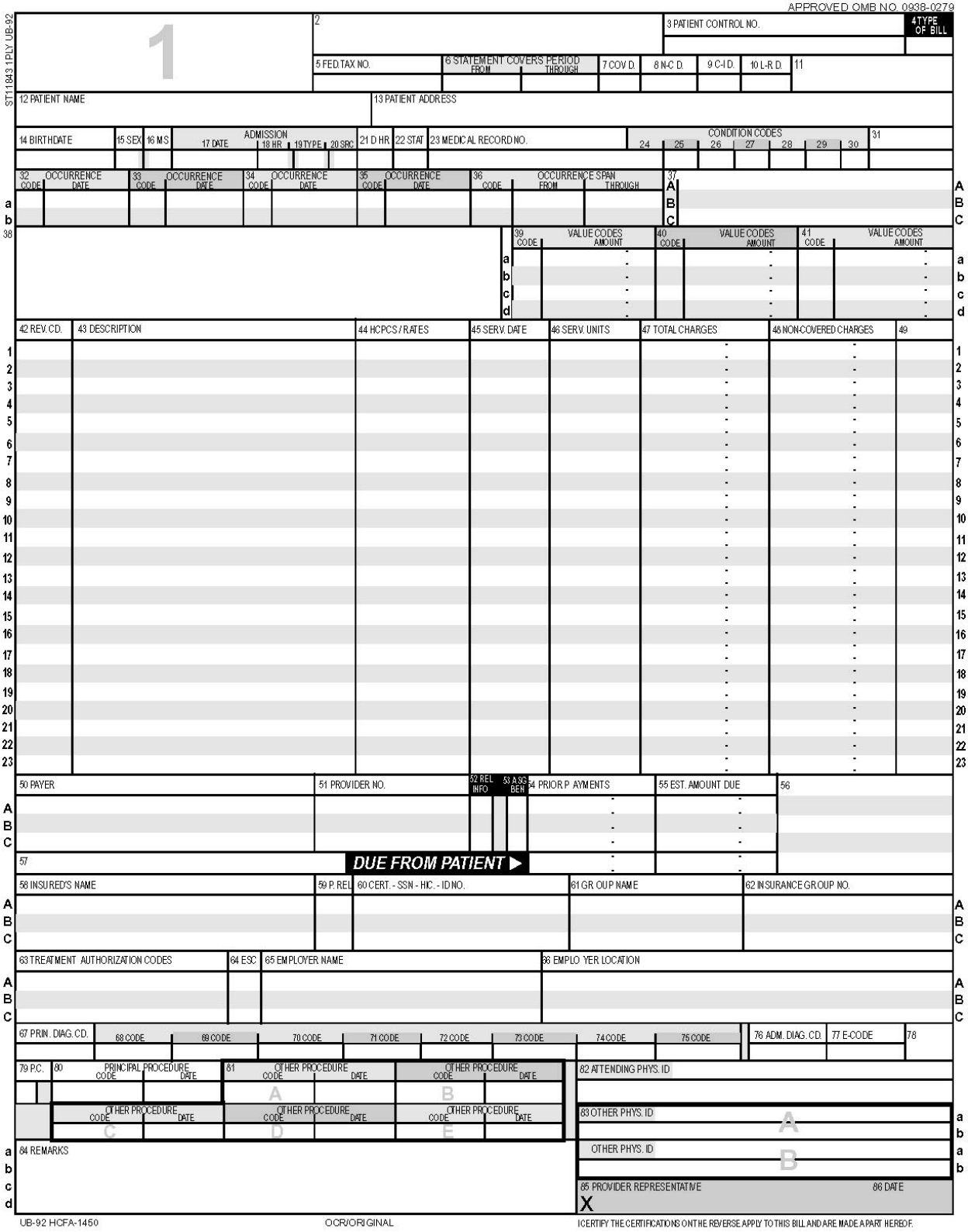
Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

## INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

# EXHIBITS



APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV. D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 M S | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | - | - | | 1 |
| 2 | | | | | | - | - | | 2 |
| 3 | | | | | | - | - | | 3 |
| 4 | | | | | | - | - | | 4 |
| 5 | | | | | | - | - | | 5 |
| 6 | | | | | | - | - | | 6 |
| 7 | | | | | | - | - | | 7 |
| 8 | | | | | | - | - | | 8 |
| 9 | | | | | | - | - | | 9 |
| 10 | | | | | | - | - | | 10 |
| 11 | | | | | | - | - | | 11 |
| 12 | | | | | | - | - | | 12 |
| 13 | | | | | | - | - | | 13 |
| 14 | | | | | | - | - | | 14 |
| 15 | | | | | | - | - | | 15 |
| 16 | | | | | | - | - | | 16 |
| 17 | | | | | | - | - | | 17 |
| 18 | | | | | | - | - | | 18 |
| 19 | | | | | | - | - | | 19 |
| 20 | | | | | | - | - | | 20 |
| 21 | | | | | | - | - | | 21 |
| 22 | | | | | | - | - | | 22 |
| 23 | | | | | | - | - | | 23 |

50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. | 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450 | OCR/ORIGINAL | I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

## RATE SCHEDULE (PROCEDURE CODE 651)

Procedure Description: Hospice Care, Routine Home Care Procedure Code **651**

| MSA Description | MSA Field No. | For FY 2003 Wage Component Subject to Index | For FY 2003 Hospice Wage Index | For FY 2003 Unweighted Amount | Effective 10/01/2002 For 2003 Hospice Rate |
|---|---|---|---|---|---|
| | | | | | |
| Bristol | 1 | $78.47 | 0.9164 | $35.73 | $170.64 |
| | | | | | |
| Roanoke | 2 | $78.47 | 0.8902 | $35.73 | $105.58 |
| | | | | | |
| Lynchburg | 3 | $78.47 | 0.968 | $35.73 | $111.69 |
| | | | | | |
| Northern Va. | 4 | $78.47 | 1.1657 | $35.73 | $127.20 |
| | | | | | |
| Danville | 5 | $78.47 | 0.9159 | $35.73 | $107.20 |
| | | | | | |
| Charlottesville | 6 | $78.47 | 1.1236 | $35.73 | $123.90 |
| | | | | | |
| Richmond | 7 | $78.47 | 1.0292 | $35.73 | $116.49 |
| | | | | | |
| Norfolk | 8 | $78.47 | 0.9123 | $35.73 | $107.32 |
| | | | | | |
| Non-MSA | 10 | $78.47 | 0.8764 | $35.73 | $104.50 |
| | | | | | |
| | | | | | |

## RATE SCHEDULE (PROCEDURE CODE 652)

Procedure Description: Hospice Care, Continuous Home Care Procedure Code **652**

| MSA Description | MSA Field No. | For FY 2003 Wage Component Subject to Index | For FY 2003 Hospice Wage Index | For FY 2003 Unweighted Amount | Effective 10/01/2002 For 2003 Hospice Rate |
|---|---|---|---|---|---|
| | | | | | |
| Bristol | 1 | $457.97 | 0.9164 | $208.55 | $628.23 |
| | | | | | |
| Roanoke | 2 | $457.97 | 0.8902 | $208.55 | $616.23 |
| | | | | | |
| Lynchburg | 3 | $457.97 | 0.968 | $208.55 | $651.86 |
| | | | | | |
| Northern Va. | 4 | $457.97 | 1.1657 | $208.55 | $742.41 |
| | | | | | |
| Danville | 5 | $457.97 | 0.9159 | $208.55 | $628.00 |
| | | | | | |
| Charlottesville | 6 | $457.97 | 1.1236 | $208.55 | $723.13 |
| | | | | | |
| Richmond | 7 | $457.97 | 1.0292 | $208.55 | $679.89 |
| | | | | | |
| Norfolk | 8 | $457.97 | 0.9123 | $208.55 | $626.36 |
| | | | | | |
| Non-MSA | 10 | $457.97 | 0.8764 | $208.55 | $609.91 |
| | | | | | |
| | | | | | |

## RATE SCHEDULE (PROCEDURE CODE 655)

Procedure Description: Hospice Care, Inpatient Respite Care Procedure Code **655**

| MSA Description | MSA Field No. | For FY 2003 Wage Component Subject to Index | For FY 2003 Hospice Wage Index | For FY 2003 Unweighted Amount | Effective 10/01/2002 For 2003 Hospice Rate |
|---|---|---|---|---|---|
| | | | | | |
| Bristol | 1 | $63.94 | 0.9164 | $54.19 | $112.78 |
| | | | | | |
| Roanoke | 2 | $63.94 | 0.8902 | $54.19 | $111.11 |
| | | | | | |
| Lynchburg | 3 | $63.94 | 0.968 | $54.19 | $116.08 |
| | | | | | |
| Northern Va. | 4 | $63.94 | 1.1657 | $54.19 | $128.72 |
| | | | | | |
| Danville | 5 | $63.94 | 0.9159 | $54.19 | $112.75 |
| | | | | | |
| Charlottesville | 6 | $63.94 | 1.1236 | $54.19 | $126.03 |
| | | | | | |
| Richmond | 7 | $63.94 | 1.0292 | $54.19 | $120.00 |
| | | | | | |
| Norfolk | 8 | $63.94 | 0.9123 | $54.19 | $112.52 |
| | | | | | |
| Non-MSA | 10 | $63.94 | 0.8764 | $54.19 | $110.23 |
| | | | | | |
| | | | | | |

## RATE SCHEDULE (PROCEDURE CODE 653)

Procedure Description: Hospice Care, General Inpatient Care Procedure Code **653**

| MSA Description | MSA Field No. | For FY 2003 Wage Component Subject to Index | For FY 2003 Hospice Wage Index | For FY 2003 Unweighted Amount | Effective 10/01/2002 For 2003 Hospice Rate |
|---|---|---|---|---|---|
| | | | | | |
| Bristol | 1 | $325.18 | 0.9164 | $182.83 | $480.82 |
| | | | | | |
| Roanoke | 2 | $325.18 | 0.8902 | $182.83 | $472.31 |
| | | | | | |
| Lynchburg | 3 | $325.18 | 0.968 | $182.83 | $497.60 |
| | | | | | |
| Northern Va. | 4 | $325.18 | 1.1657 | $182.83 | $561.89 |
| | | | | | |
| Danville | 5 | $325.18 | 0.9159 | $182.83 | $480.66 |
| | | | | | |
| Charlottesville | 6 | $325.18 | 1.1236 | $182.83 | $548.20 |
| | | | | | |
| Richmond | 7 | $325.18 | 1.0292 | $182.83 | $517.51 |
| | | | | | |
| Norfolk | 8 | $325.18 | 0.9123 | $182.83 | $479.49 |
| | | | | | |
| Non-MSA | 10 | $325.18 | 0.8764 | $182.83 | $467.82 |
| | | | | | |
| | | | | | |

## RATE SCHEDULE (PROCEDURE CODE 658)

Procedure Description: Hospice Care, Nursing Facility Resident Procedure Code **658**

| MSA Description | MSA Field No. | For FY 2003 Wage Component Subject to Index | For FY 2003 Hospice Wage Index | For FY 2003 Unweighted Amount | Effective 10/01/2002 For 2003 Hospice Rate |
|---|---|---|---|---|---|
| | | | | | |
| Bristol | 1 | IC | n/a | n/a | IC |
| | | | | | |
| Roanoke | 2 | IC | n/a | n/a | IC |
| | | | | | |
| Lynchburg | 3 | IC | n/a | n/a | IC |
| | | | | | |
| Northern Va. | 4 | IC | n/a | n/a | IC |
| | | | | | |
| Danville | 5 | IC | n/a | n/a | IC |
| | | | | | |
| Charlottesville | 6 | IC | n/a | n/a | IC |
| | | | | | |
| Richmond | 7 | IC | n/a | n/a | IC |
| | | | | | |
| Norfolk | 8 | IC | n/a | n/a | IC |
| | | | | | |
| Non-MSA | 10 | IC | n/a | n/a | IC |
| | | | | | |
| | | | | | |

Procedure code 658 must be billed in conjunction with either procedure code 651 or 652. The hospice will be reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.

This in an individually calculated reimbursement rate (IC).